Health Care Quality and Cost Council Committee Report

Committee Name: End of Life
Committee Chair: Jim Conway
Date: October 15, 2008

1. Status of items referred to the Committee by the Council
    a. Dartmouth Atlas Variation—Committee had a highly successful special meeting. Report attached.

2. Committee recommendations to the Council
    a. The Sub-Committee integrates its activities with the soon to be appointed under Chapter 305 Expert Panel by the QCC, EOHHS, and the Betsy Lehman Center. This will give further focus and allow for alignment and best use of the limited final resources along with talent and time.
    b. The committee convene a winter or early spring public meeting, linked to the kick off of the Expert Panel, for hospital executive leadership along with hospice, home care, and nursing home executive leadership to convey:
        i. The goals and expectations of the QCC
        ii. The extent of end of life variation in the Commonwealth
        iii. National and state best practices including minority and underserved populations
        iv. Reports on individual provider delivery of end of life care
        v. Opportunities for immediate collaboration and improvement
    c. QCC and the Expert Panel take under advisements the recommendations from the special meeting on variation in end of life care
        i. MA should consider regional planning / DON for hospices
        ii. MA should set requirement that all hospices be accredited
        iii. Consider a statewide collaborative with IHI on end of life care
        iv. Consider a project with Minnesota--twinning
        v. Examine the links with hospice and bridge program- very useful, big opportunity
        vi. Establish concrete pilots, drilling down, experts coming up with a list of things to try
        vii. Implement a state-wide palliative care conference using Oregon model
        viii. Pursue possible meeting collaboration / funding with HRET / AHRQ
        ix. Engage with the hospitals/hospices/communities in MA on the leading edge of this work
        x. Develop a model of idealized design of the palliative care experience- look at variation- economic, flow, integration

xi. Given extent of existing resources and action orientation, expert panel focus should be on driving improvement

3. Committee accomplishments
    a. Meeting on schedule with the Chronic Care Committee—September 3, 2008
    b. Advanced the POLST/MOLST initiative in conjunction with the Transition Task Force
    c. Conducted a special meeting on Variation in EOL Care—September 4, 2008
    d. Attended and sought counsel from the Advisory Committee meeting—September 24, 2008

4. Progress on meeting FY08 Council recommendations
    1. Strategy: The Commonwealth of Massachusetts Executive Office of Health and Human Services (EOHHS) should implement a statewide public health educational campaign by September, 2008…
    Status:
        1. *Affirmed in Chapter 305 Section 42: Notwithstanding any general or special law to the contrary, on or before January 1, 2009, the executive office of health and human services, in consultation with the commission on end–of-life care established by section 480 of chapter 159 of the acts of 2000, shall initiate a public aware*
        2. *End of Life Commission not funded*
        3. *Existing national and state campaign resources already exist and provide a strong base for moving forward now.*
        4. *Pursue alternate approaches for Campaign*
    2. Strategy: Hospitals, nursing homes, physicians and other providers should implement, by 2010, a process for communicating patients' wishes for care at the end of life, similar to the Physician Order for Life Sustaining Treatment (POLST) processes currently in use in Oregon, Washington, New York, West Virginia, and other states.
    Status:
        1. *Affirmed in Chapter 305 Section 43: Notwithstanding any general or special law to the contrary, the executive office of health and human services, in consultation with the commission on end-of-life care established by section 480 of chapter 159 of the acts of 2000, shall establish a pilot program to test the implementation of the physician order for life-sustaining treatment paradigm program to assist individuals in communicating end-of-life care directives across care settings in at least 1 region of the commonwealth….*
        2. *Strong multi-stakeholder initiative underway*
        3. *Grant funding sought to support pilot*
        4. *Other funding options being identified.*
    3. Strategy: Hospitals, extended care facilities, and home health care organizations should, by March, 2009, offer formal hospice and

palliative care programs to their terminally ill patients, and should ensure that these programs meet the needs of patients with different cultural expectations at the end of life.
Status:
1. *Pending*
2. *Data on hospital programs is available on AHA Survey of Hospitals*
3. *Recent report, America's Care of Serious Illness: A State-by-State Report Card on Access to Palliative Care in our Nation's Hospitals, based on this data, gave Commonwealth of MA a "C"*
    a. *~50% medium / large hospitals have Palliative Care Program*
4. *Identify options to measure presence of formal hospice and palliative care programs for extended care and home care organizations.*

4. Strategy: The Board of Registration in Medicine should require hospitals to submit a plan for ensuring that all clinical professionals who care for patients at the end of life are educated in the delivery of culturally sensitive care.
   Status:
   1. *Clarification: Intent is to accommodate within Patient Care Assessment Plan*
   2. *Discussions begun with BRM PCAC*
5. Strategy: Payers should adopt policies and standards to support and improve the process of care at the end of life.
   Status:
   1. *Pending*
   2. *Considerable attention has already been given this area by a number of payers*

5. Progress on establishing performance measurement benchmarks, in accordance with FY08 Council recommendations
   Status:
   1. Pending
   2. Consider developing consistent with National Quality Forum and NQF Priority Partners Recommendations

6. Next Steps: Per Above
   a. Integrate efforts with Expert Panel
   b. POLST / MOLST Initiative and identify funding
   c. Formal hospice and palliative care programs in extended care and nursing home facilities.
   d. Alternatives to resource the Campaign
   e. Planning Winter / Spring State Meeting on EOL Care
   f. Identify performance metrics

Special End-of-Life Meeting: Variation in Care September 4, 10 AM-12 PM @ IHI

1. ~ 40 Attendees: EOL and Chronic Care Members, content experts, interested parties
2. Problem Definition and Goals for Meeting
    - Wide variation in all aspects of end of life care across state
    - Some regions and organizations in MA show significantly more effective use
3. Dartmouth Findings: Julie Lewis, Dartmouth
    - What if the nation was practicing end-of-life care like Massachusetts?
        i. An Additional $55 billion for Medicare
    - What if Massachusetts was practicing end-of-life care like Minnesota?
        i. A savings of $2.3 billion on total spending in Massachusetts
    - Policy Implications
        i. Healthcare capacity directly affects volume of services and spending.
        ii. Additions of skilled nursing and home health (without an incentive reduce utilization of inpatient facilities) will not reduce spending.
        iii. High numbers of unique physicians participating in one case leads to poor care coordination.
        iv. Poor care coordination leads to increased costs and often lower quality of care.
        v. Incentives must be aligned to reward patient-centric, efficient care with an emphasis on capacity planning.
        vi. Policy efforts must increase accountability for cost, quality, and capacity.
4. Using Variation Data to Improve Quality and Cost, Lindsay Martin IHI
    - Primary drivers include: Hospital care, coordination of care, patient and family support, provider supply. Secondary drivers also detailed.
5. General Discussion:
    - Factors in play include: competition, regional collaboration, patient / family readiness, provider understanding, starting the conversation early, historical reimbursement issues, integration of palliative care into oncology care, culturally competent care, patient navigation, reluctance of physicians to give up hope and refer, positive impact of hospitalists on hospice referral, importance of conversation around wishes on admission,
    - Extensive resources available and best practice models in state, training in medical schools and residency is improving, research underway in state on cultural barriers
    - National Quality Forum placing major emphasis on palliative care.
6. Recommendations to QCC and Expert Panel
    - MA should consider regional planning / DON for hospices
    - MA should set requirement that all hospices be accredited
    - Consider a statewide collaborative with IHI on end of life care
    - Consider a project with Minnesota--twinning
    - Examine the links with hospice and bridge program- very useful, big opportunity
    - Establish concrete pilots, drilling down, experts coming up with a list of things to try
    - Implement a state-wide palliative care conference using OR model
    - Pursue possible meeting collaboration / funding with HRET / AHRQ
    - Engage with the hospitals/hospices/communities in MA on the leading edge of this work
    - Develop a model of idealized design of the palliative care experience- look at variation-economic, flow, integration
    - Given extent of existing resources and action orientation, expert panel focus should be on driving improvement
7. Closing Points:
    - Dartmouth very interested in taking this conversation to a larger audience and volunteered to help
    - Strong interest in a statewide meeting with hospitals, home care organizations, hospices, and nursing home/extended care facilities
    - Strong community forming with an interest in moving improvement forward now.